Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Screening Immigrant Children

TO THE EDITOR: The excellent study of parasites in Central American immigrant children by Sarfaty, Rosenberg, Siegel and Levin[1] presents results similar to those we have encountered in screening Southeast Asian children who were recent immigrants.[2]

As a simple rule of thumb it seems reasonable to screen all immigrant children from less developed nations for parasitism unless they have spent their lives exclusively in a middle-class urban environment. Screening with a Tb skin test and a hemoglobin determination are also suggested.

However, I would suggest this course only for those who have been in the United States for less than three years. Clinically it has been my experience that if immigrants have been in this country longer, their parasites have become commensals or have died off, especially given an improved diet in the United States. This same diet makes danger from any remaining parasites much less than on first arrival when nutrition may be compromised. Sarfaty and associates do not mention how long the children in their study had been in the United States, and perhaps they would care to comment on this point.

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REFERENCES

1. Sarfaty M, Rosenberg Z, Siegel J, et al: Intestinal parasites in immigrant children from Central America. West J Med 1983 Sep; 139: 329-331
2. Goldenring JM, Davis J: Pediatric screening of Southeast Asian immigrants. Clin Pediatr 1982 Sep; 21:613-616

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Drs Levin and Sarfaty Reply

TO THE EDITOR: We would like to thank Dr Goldenring for his comments on our article. All of the immigrant children we studied were receiving their first physical examination in the United States and had been in this country for less than a year.

We know of Dr Goldenring's experience with refugees, both from personal contact and from his several publications, and it is not to be taken lightly. Our own experience, however, conflicts somewhat with his. We have continued to find a significant incidence of parasitosis in Latin American refugees even beyond three years. This has been the experience of other researchers as well.[1,2] As with most such discrepancies, the truth lies somewhere in between. It appears that certain specific parasites, such as hookworm, do indeed tend to recede after the refugee has spent about three years in this country.[3]

Further, we should add, the Central American patients we saw in our clinic in San Francisco were almost all working, middle-class and upper middle-class and yet were still quite infested with parasites.

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REFERENCES

1. Hargus EP, Lepow M, Lau T, et al: Intestinal parasitosis in childhood populations of Latin origin. Clinical Pediatr 1976 Oct; 15:927-929
2. Solomon W, Sherman L, Weil AJ: Chronic helminthic infection among Puerto Ricans residing in the continental U.S. J Chron Dis 1964 May; 17:439
3. Pierz JJ, Lau T, Lepow ML: Prevalence of parasites in Puerto Rican and black children of Hartford, Connecticut. Conn Med 1973 Jun; 37: 291-294

Opportunistic Infection, Asthma and Corticosteroid Therapy

TO THE EDITOR: A recent report in this journal[1] described the cases of two patients with asthma in whom corticosteroid therapy resulted in death by opportunistic infection: *Legionella pneumophila* pneumonia and *Pseudomonas aeruginosa* endocarditis. Our review of the literature suggests that such events are rare. We report an additional case in order to draw attention to this potential complication in asthmatic patients.

Report of Case

A 52-year-old woman with severe asthma, whose treatment included prednisone at a daily dose varying between 15 and 30 mg, was admitted to hospital with exacerbation of her condition. Because of slow improvement, prednisone administration was continued after discharge at 80 mg per day. Three weeks later she returned with bilateral pneumonia. Shock and respiratory failure developed and the patient died despite appropriate antibiotic and vigorous supportive therapy. Sputum cultures yielded heavy growth of *Nocardia asteroides* and *Pseudomonas aeruginosa*. Autopsy revealed extensive necrotizing pneumonia with the same organisms.

Comment

As noted by Leung and co-workers, most discussions of respiratory failure and death in cases of asthma